STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K080	A. BUILDING 00 B. WING	03/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTYLES HOMECARE LLC	107 FEDERAL DRIVE CHESTERFIELD, IN 46017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000 Bldg. 00	This visit was for a home health federal recertification survey. This visit resulted in a partial extended survey. Survey date: 3/23/15 - 3/27/15 Facility #: 012685 Medicaid Vendor #: 201058730 Surveyor: Ingrid Miller, PHNS, RN Skilled unduplicated census: 23 Quality Review: Joyce Elder, MSN, BSN, RN March 31, 2015	G 000	Plan of correction completed and submitted	
G 121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation, interview, and	G 121	The DON/ADON held an	04/03/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	review of policies and procedures, the agency failed to ensure the home health aide had provided services in accordance with infection control policies and procedures in 1 of 3 home visit observations (Patient #2) with a home health aide (Employee E , Home Health Aide). Findings 1. At a home visit observation on 3/25/15 at 2 PM, Employee E, Home Health Aide, was observed at the home of patient #3. When Employee E took off her gloves after removing clothing from patient #3, she applied clean gloves without washing her hands. This was prior to giving a shower to patient #3. 2. On 3/25/15 at 2:37 PM, Employee A, the administrator, indicated Employee E did not follow infection control procedures. 3. The agency procedure titled "Standard Infection Control Procedures for Home Care" with a date of August 2002 stated, "Wash hands before and after client care.		inservice for all nursing staff on 4/3/15 on "Standard infection control procedures" Policy #N-100 Policy purpose is to provide protection against the transmission of infection. To comply with the guidelines of OSHA and CDC in creating a safe environment for all health care workers and other caregivers in the home setting. Part one of the procedure specifically reads to wash hands before and after client care and after removing gloves. Handwashing policy #N-100 has a purpose to prevent the spread of infection by contaminated hands. To remove soil and transient organisms from the hands and reduce total microbial counts over time. Each employee received a competency evaluation check off by an RN for handwashing procedure. All staff will follow policies in place. The RNs will observe that these policies are being enforced during their supervisory visits of the home health aides. The DON/ADON will ensure that this deficiency is corrected and will not occur in the future	
G 141	484.14(e) PERSONNEL POLICIES			

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Bldg. 00	Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. Based on policy and employee file review and interview, the home health agency failed to ensure home health aides were entered on and in good standing on the state aide registry for 2 of 4 home health aide files reviewed (F, G). Findings: 1. Employee File F, date of hire 4/9/13 and first patient contact 4/15/13, failed to evidence the home health aide was entered on and in good standing on the state aide registry. 2. Employee File G, date of hire 3/28/14 and first patient contact 3/29/14, failed to evidence the home health aide was entered on and in good standing on the state aide registry. 3. On 3/27/15 at 10:45 AM, Employee A, administrator, indicated Employees F and G were not entered on the state aide registration as home health aides. 4. The agency policy titled "License, Registration, or certification requirements" with no date stated, "If a	G 141	Based on this deficiency above the following addendums have been made to the home health aide hiring requirements. If a CNA is hired to fill a home health aide position the CNA must complete and pass the written home health aide exam. The CNA must also complete the competency evaluation check off with proficiency by the RN. The home health aide must be entered on and in good standing with the state aide registry. A copy of the employees current license certification shall be maintained in his/her personnel file. The CNA's in question on the deficiency were corrected on 3/30/15	03/30/2015

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	position requires ... certification, it shall be the employee's responsibility to keep these documents current ... a copy of the employee's current license certification shall be maintained in his / her personnel file."			
G 158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and agency policy review and interview, the agency failed to ensure services had been provided in accordance with physician orders in 3 (#2, # 5, #7) of 10 records reviewed. The findings include: Regarding blood pressures omitted at skilled nurse visits 1. Clinical record #2, start of care 8/20/12 with a diagnosis of lisssencephaly, included a plan of care for the certification period of 2/18/15 - 2/18/15. This plan of care evidenced	G 158	The DON/ADON held a meeting with all RN's and LPN's. The inservice education meeting content included discussion of the policy "Standards of practice", Policy #C-110. The meeting was held on 4/3/2015. Policy includes in section #3 of this policy that client care will be provided under the Plan of Care established by a physician. All nursing visits are to be followed by the orders on the plan of care signed by the physician. Instructed the RN's and LPN's that if the informal caregiver and/or power of attorney for the patient has requested something to not be done that is on the care plan, physician must be notified and careplan updated. The RN's and	04/03/2015

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	vital signs would be done at each skilled nurse visit. At skilled nurse visits on 2/18/15, 2/19/15, 2/20/15, 2/21/15, 2/22/15, 2/23/15, 2/24/15, 2/25/15, 2/26/15, 2/27/15, 2/28/15, 3/1/15, 3/2/15, 3/3/15, 3/5/15, and 3/6/15, blood pressure was not taken. 2. Clinical record #7, start of care 9/1/12 and diagnosis of severe mental retardation, included a plan of care for the certification period of 2/18/15 - 4/18/15. This plan of care evidenced vital signs would be done at each skilled nurse visit. At skilled nurse visits on 2/18/15, 2/19/15, 2/20/15, 2/21/15, 2/22/15, 2/23/15, 2/24/15, 2/25/15, 2/26/15, 2/27/15, 2/28/15, 3/1/15, 3/2/15, 3/3/15, 3/5/15, and 3/6/15, blood pressure was not taken. On 2/26/15 at 1:35 PM, Employee A, the administrator, indicated the plan of care had not been written correctly for clinical records #2 and #7. The informal caregiver and power of attorney for the patients did not want the patients to have blood pressures done at each visit. Regarding a missed home health aide visit 3. Clinical record #5, start of care 4/1/14		LPN's reeducated that vital signs include all the following: blood pressure, heart rate, respirations and temperature, If one of these are requested to be omitted, the physician is to be notified and the careplan should specifically reflect this. 10% of all clinical records will be audited quarterly for evidence that standards of practice/plan of care physician orders are being followed with accuracy. Inservice education meeting for clinical documentation policy #C-680 held on 4/3/15 by DON/ADON. If a missed visit occurs, a missed visit report will be completed. The reason services were not provided and documentation to include the physician was notified. The nursing staff will follow this policy that is in place. 10% of all clinical records will be audited quarterly for evidence that all visits are being followed on the plan of care signed by the physician, or that a missed visit report was completed, reason for the missed visit and that the physician was notified per policy	

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	and diagnosis of osteoarthritis, included a plan of care for the certification period of 1/26/15 - 3/26/15. This plan of care identified the home health aide would visit the patient 4 - 7 days a week. A. The record evidenced 3 Home health aide visits had occurred the week of 2/2/15 - 2/8/15. These visits occurred on 2/2/15, 2/4/15, and 2/6/15. There was no documentation that the physician had been contacted due to the lack of visits. B. On 3/26/15 at 4:05 PM, Employee A, administrator, stated, "Not documented, not done." 4. The agency policy titled "Plan of Care" with no date stated, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care."			
G 224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE			

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	Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on agency policy review, clinical record review, and interview, the agency failed to ensure the registered nurse updated the home health aide plan of care at least every 60 days as required by agency policy in 1 of 7 clinical records reviewed of patients receiving home health aide services (#3). Findings include: 1. The policy titled "Home Health Aide Care Plan" with no date stated, "The Home Health Care Plan shall be reviewed and updated by the registered nurse minimally every 60 days. 2. Clinical record #3, start of care 7/17/14, contained a physician's plan of care for certification period 3/13/15 - 5/11/15. The record evidenced an aide care plan with review dates of 7/18/14, 9/11/14, 11/10/14, and 3/11/15. 3. On 3/26/15 at 3:26 PM, Employee A, the administrator, indicated the aide care plan should be reviewed every 60 days.	G 224	The DON/ADON held an inservice/education meeting for all RN's to review the policy for "Careplans" Policy # C-660. The survey deficiency recognized one of the careplans were not signed by an RN that it was reviewed during the 60day recertification visit. All RN's reeducated that the policy reads the care plan shall be reviewed, evaluated and revised at a minimum of every 60 days and as needed based upon the clients health status, ongoing client assessments, caregiver support systems, and effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff members. This policy will followed by evidence of clinical records to be free of this deficiency with each quarterly evaluation of a minimum of 10% of clinical records reviewed.	04/03/2015

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G 331 Bldg. 00	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. Based on clinical record review and interview, the agency failed to ensure the registered nurse completed an initial assessment visit before the home health aide visited for 1 of 10 records reviewed (#4). Findings include: 1. Clinical records #1, start of care 2/26/15 and diagnosis of hyponatremia, contained a home health aide visit conducted by the Employee F on 2/26/15 at 8 AM - 6 PM. The RN conducted the start of care assessment on 2/26/15 from 1 PM - 2:30 PM. 2. On 3/26/15 at 4 PM, Employee A, administrator, indicated the initial assessment visit and start of care (SOC) assessment had not occurred when the Employee F went out to visit the patient on 2/26/15 at 8 AM. The SOC assessment did not occur until 1 PM on 2/26/15.	G 331	The DON/ADON held an inservice/education meeting on 4/3/15 for all staff regarding the policy for admission of a patient. The policy indicates the services will be initiated after the assessment by the RN, unless documentation supports alternate plans based on the client needs and wishes. The deficiency indicated the home health aide completed a home visit prior to the RN doing the initial assessment visit. Reeducation completed to all the home health aides that if they would happen to receive a call by a client needing them to come for their care, the home health aide must first notify the office so that coordination of the start of care is effective for the safety of the client and the caregiver. The RN is reeducated to inform the client that he/she must notify the office of any hospital admission or discharge so that the much needed care is not overlooked by the agency and avoid the client being without the correct care. This policy will be followed by all staff	04/03/2015

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N 000 Bldg. 00	This visit was for a state relicensure survey. Survey date: 3/23/15 - 3/27/15 Facility #: 12685 Medicaid Vendor #: 201058730 Surveyor: Ingrid Miller, PHNS, RN Skilled unduplicated census: 23 Quality Review: Joyce Elder, MSN, BSN, RN March 31, 2015	N 000	Plan of correction completed and submitted	
N 458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:			

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	(1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on policy and employee file review and interview, the home health agency failed to ensure home health aides were entered on and in good standing on the state aide registry for 2 of 4 home health aide files reviewed (F, G). Findings: 1. Employee File F, date of hire 4/9/13 and first patient contact 4/15/13, failed to evidence the home health aide was entered on and in good standing on the state aide registry. 2. Employee File G, date of hire 3/28/14 and first patient contact 3/29/14, failed to evidence the home health aide was entered on and in good standing on the state aide registry. 3. On 3/27/15 at 10:45 AM, Employee A, administrator, indicated Employees F and G were not entered on the state aide registration as home health aides. 4. The agency policy titled "License, Registration, or certification	N 458	Based on this deficiency above the following addendums have been made to the home health aide hiring requirements. If a CNA is hired to fill a home health aide position the CNA must complete and pass the written home health aide exam. The CNA must also complete the competency evaluation check off with proficiency by the RN. The home health aide must be entered on and in good standing with the state aide registry. A copy of the employees current license certification shall be maintained in his/her personnel file. The CNA's in question on the deficiency were corrected on 3/30/15	03/30/2015

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	requirements" with no date stated, "If a position requires ... certification, it shall be the employee's responsibility to keep these documents current ... a copy of the employee's current license certification shall be maintained in his / her personnel file."			
N 470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, interview, and review of policies and procedures, the agency failed to ensure the home health aide had provided services in accordance with infection control policies and procedures in 1 of 3 home visit observations (Patient #2) with a home health aide (Employee E , Home Health Aide). Findings 1. At a home visit observation on 3/25/15 at 2 PM, Employee E, Home Health Aide, was observed at the home of	N 470	The DON/ADON held an inservice for all nursing staff on 4/3/15 on "Standard infection control procedures" Policy #N-100 Policy purpose is to provide protection against the transmission of infection. To comply with the guidelines of OSHA and CDC in creating a safe environment for all health care workers and other caregivers in the home setting. Part one of the procedure specifically reads to wash hands before and after client care and after removing gloves. Handwashing policy #N-100 has a purpose to prevent the spread of infection by contaminated	04/03/2015

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	patient #3. When Employee E took off her gloves after removing clothing from patient #3, she applied clean gloves without washing her hands. This was prior to giving a shower to patient #3. 2. On 3/25/15 at 2:37 PM, Employee A, the administrator, indicated Employee E did not follow infection control procedures. 3. The agency procedure titled "Standard Infection Control Procedures for Home Care" with a date of August 2002 stated, "Wash hands before and after client care.		hands. To remove soil and transient organisms from the hands and reduce total microbial counts over time. Each employee received a competency evaluation check off by an RN for handwashing procedure. All staff will follow policies in place. The RNs will observe that these policies are being enforced during their supervisory visits of the home health aides. The DON/ADON will ensure that this deficiency is corrected and will not occur in the future	
N 522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review and interview, the agency failed to ensure services had been provided in accordance with physician orders in 3 (#2, # 5, #7) of 10 records reviewed. The findings include: Regarding blood pressures omitted at skilled nurse visits	N 522	The DON/ADON held a meeting with all RN's and LPN's. The inservice education meeting content included discussion of the policy "Standards of practice", Policy #C-110. The meeting was held on 4/3/2015. Policy includes in section #3 of this policy that client care will be provided under the Plan of Care established by a physician. All nursing visits are to be followed by the orders on the plan of care signed by the physician. Instructed the RN's and LPN's that if the informal caregiver and/or power of	04/03/2015

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	1. Clinical record #2, start of care 8/20/12 with a diagnosis of lisssencephaly, included a plan of care for the certification period of 2/18/15 - 2/18/15. This plan of care evidenced vital signs would be done at each skilled nurse visit. At skilled nurse visits on 2/18/15, 2/19/15, 2/20/15, 2/21/15, 2/22/15, 2/23/15, 2/24/15, 2/25/15, 2/26/15, 2/27/15, 2/28/15, 3/1/15, 3/2/15, 3/3/15, 3/5/15, and 3/6/15, blood pressure was not taken. 2. Clinical record #7, start of care 9/1/12 and diagnosis of severe mental retardation, included a plan of care for the certification period of 2/18/15 - 4/18/15. This plan of care evidenced vital signs would be done at each skilled nurse visit. At skilled nurse visits on 2/18/15, 2/19/15, 2/20/15, 2/21/15, 2/22/15, 2/23/15, 2/24/15, 2/25/15, 2/26/15, 2/27/15, 2/28/15, 3/1/15, 3/2/15, 3/3/15, 3/5/15, and 3/6/15, blood pressure was not taken. On 2/26/15 at 1:35 PM, Employee A, the administrator, indicated the plan of care had not been written correctly for clinical records #2 and #7. The informal caregiver and power of attorney for the patients did not want the patients to have blood pressures done at each visit.		attorney for the patient has requested something to not be done that is on the care plan, physician must be notified and careplan updated. The RN's and LPN's reeducated that vital signs include all the following: blood pressure, heart rate, respirations and temperature, If one of these are requested to be omitted, the physician is to be notified and the careplan should specifically reflect this. 10% of all clinical records will be audited quarterly for evidence that standards of practice/plan of care physician orders are being followed with accuracy. Inservice education meeting for clinical documentation policy #C-680 held on 4/3/15 by DON/ADON. If a missed visit occurs, a missed visit report will be completed. The reason services were not provided and documentation to include the physician was notified. The nursing staff will follow this policy that is in place. 10% of all clinical records will be audited quarterly for evidence that all visits are being followed on the plan of care signed by the physician, or that a missed visit report was completed, reason for the missed visit and that the physician was notified per policy	

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	Regarding a missed home health aide visit 3. Clinical record #5, start of care 4/1/14 and diagnosis of osteoarthritis, included a plan of care for the certification period of 1/26/15 - 3/26/15. This plan of care identified the home health aide would visit the patient 4 - 7 days a week. A. The record evidenced 3 Home health aide visits had occurred the week of 2/2/15 - 2/8/15. These visits occurred on 2/2/15, 2/4/15, and 2/6/15. There was no documentation that the physician had been contacted due to the lack of visits. B. On 3/26/15 at 4:05 PM, Employee A, administrator, stated, "Not documented, not done." 4. The agency policy titled "Plan of Care" with no date stated, "Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care."			
N 540 Bldg. 00	410 IAC 17-14-1(a)(1)(A) Scope of Services Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:			

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	(A) Make the initial evaluation visit. Based on clinical record review and interview, the agency failed to ensure the registered nurse completed an initial assessment visit before the home health aide visited for 1 of 10 records reviewed (#4). Findings include: 1. Clinical records #1, start of care 2/26/15 and diagnosis of hyponatremia, contained a home health aide visit conducted by the Employee F on 2/26/15 at 8 AM - 6 PM. The RN conducted the start of care assessment on 2/26/15 from 1 PM - 2:30 PM. 2. On 3/26/15 at 4 PM, Employee A, administrator, indicated the initial assessment visit and start of care (SOC) assessment had not occurred when the Employee F went out to visit the patient on 2/26/15 at 8 AM. The SOC assessment did not occur until 1 PM on 2/26/15.	N 540	The DON/ADON held an inservice/education meeting on 4/3/15 for all staff regarding the policy for admission of a patient. The policy indicates the services will be initiated after the assessment by the RN, unless documentation supports alternate plans based on the client needs and wishes. The deficiency indicated the home health aide completed a home visit prior to the RN doing the initial assessment visit. Reeducation completed to all the home health aides that if they would happen to receive a call by a client needing them to come for their care, the home health aide must first notify the office so that coordination of the start of care is effective for the safety of the client and the caregiver. The RN is reeducated to inform the client that he/she must notify the office of any hospital admission or discharge so that the much needed care is not overlooked by the agency and avoid the client being without the correct care. This policy will be followed by all staff	04/03/2015
N 550 Bldg. 00	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed			

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	practical nurses and other individuals as appropriate. Based on agency policy review, clinical record review, and interview, the agency failed to ensure the registered nurse updated the home health aide plan of care at least every 60 days as required by agency policy in 1 of 7 clinical records reviewed of patients receiving home health aide services (#3). Findings include: 1. The policy titled "Home Health Aide Care Plan" with no date stated, "The Home Health Care Plan shall be reviewed and updated by the registered nurse minimally every 60 days. 2. Clinical record #3, start of care 7/17/14, contained a physician's plan of care for certification period 3/13/15 - 5/11/15. The record evidenced an aide care plan with review dates of 7/18/14, 9/11/14, 11/10/14, and 3/11/15. 3. On 3/26/15 at 3:26 PM, Employee A, the administrator, indicated the aide care plan should be reviewed every 60 days.	N 550	The DON/ADON held an inservice/education meeting for all RN's on 4/3/15 to review the policy for "Careplans" Policy # C-660. The survey deficiency recognized one of the careplans were not signed by an RN that it was reviewed during the 60day recertification visit. All RN's reeducated that the policy reads the care plan shall be reviewed, evaluated and revised at a minimum of every 60 days and as needed based upon the clients health status, ongoing client assessments, caregiver support systems, and effectiveness of the interventions in achieving progress toward goals. All updated entries must be signed and dated by the Registered Nurse. All changes will be communicated to appropriate staff members. This policy will followed by evidence of clinical records to be free of this deficiency with each quarterly evaluation of a minimum of 10% of clinical records reviewed.	04/03/2015
N 597	410 IAC 17-14-1(l)(1)(B) Scope of Services			

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Bldg. 00	Rule 14 Sec. (1)(I)(1) The home health aide shall: (B) be entered on and be in good standing on the state aide registry. Based on policy and employee file review and interview, the home health agency failed to ensure home health aides were entered on and in good standing on the state aide registry for 2 of 4 home health aide files reviewed (F, G). Findings: 1. Employee File F, date of hire 4/9/13 and first patient contact 4/15/13, failed to evidence the home health aide was entered on and in good standing on the state aide registry. 2. Employee File G, date of hire 3/28/14 and first patient contact 3/29/14, failed to evidence the home health aide was entered on and in good standing on the state aide registry. 3. On 3/27/15 at 10:45 AM, Employee A, administrator, indicated Employees F and G were not entered on the state aide registration as home health aides. 4. The agency policy titled "License, Registration, or certification requirements" with no date stated, "If a position requires ... certification, it shall	N 597	Based on this deficiency above the following addendums have been made to the home health aide hiring requirements. If a CNA is hired to fill a home health aide position the CNA must complete and pass the written home health aide exam. The CNA must also complete the competency evaluation check off with proficiency by the RN. The home health aide must be entered on and in good standing with the state aide registry. A copy of the employees current license certification shall be maintained in his/her personnel file. The CNA's in question on the deficiency were corrected on 3/30/15	03/30/2015

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	be the employee's responsibility to keep these documents current ... a copy of the employee's current license certification shall be maintained in his / her personnel file."			
N 606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on policy and clinical record review and interview, the agency failed to ensure the registered nurse (RN) made an on-site visit to the patient's home no less frequently than every 30 days in 4 of 4 records reviewed of patients receiving home health aide only services (#3, #5, #6, #10) for over 30 days. The findings include: 1. Clinical record 3, start of care (SOC) 7/17/14 and diagnosis of arthritis, included plans of care for the certification periods of 1/12/15 - 3/12/15 and 3/13/15 - 5/11/15. The plan of care for the certification period of 1/12/15 -	N 606	The DON/ADON held an inservice/education meeting with the RN's in regards to the deficiency of frequency of supervising the home health aides. The RN's were scheduled to complete a supervisory visit every 60 days on non skilled patients and every 14 days on skilled patients. This process was being done in error. The state regulations state the home health aides are required to have a supervisory visit every 30 days on non skilled patients and 14 days on skilled patients. The agency policy was revised immediately and all RN's educated on this process. The policy shall provide home health aide services under the direction and supervision of a registered nurse when personal care services are indicated and ordered by the physician. The	04/03/2015

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	3/23/15 included orders for the HHA to visit 2- 4 hours a day, 5 - 7 days a week, 3 - 4 days a week for 8 weeks to assist with shower, shampoo, bathing, dressing, nail / skin / oral / hair care . HHA will provide medication reminders ... diabetic menu planning and menu preparation. The second plan of care for the certification period of 3/13/15 - 5/11/15 included orders for the HHA to visit 2 - 4 hours a day, 0 - 1 day / week, and 2 - 4 hours a day 5 - 7 days a week for weeks 2 - 8. Supervision by the RN did not occur every 30 days. A. The RN visited the patient and completed supervisory visits on 1/8/15 and 3/11/15. B. The home health aide completed visits on 1/12/15, 1/13/15, 1/14/15, 1/15/15, 1/16/15, 1/19/15, 1/20/15, 1/21/15, 1/22/15, 1/23/15, 1/26/15, 1/27/15, 1/28/15, 1/30/15, 2/3/15, 2/4/15, 2/5/15, 2/6/15, 2/9/15, 2/10/15, 2/11/15, 2/13/15, 2/16/15, 2/18/15, 2/20/15, 2/23/15, 2/24/15, 2/25/15, 2/27/15, 3/2/15, 3/4/15, 3/6/15, 3/9/15, 3/11/15, and 3/13/15 and 3/25/15. C. On 3/26/15 at 3:45 PM, Employee A, the administrator, indicated the supervisory visits had not occurred every 30 days. .		purpose is to observe the aide in providing care to the patients and to assess competency in basic skills as well as delegated nursing tasks. One specific RN has been assigned to schedule these supervisory visits and another RN has been assigned to keep an audit flow sheet to ensure that the supervisory visits are being completed timely.	

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	2. Clinical record 5, SOC 4/1/14 and diagnosis of osteoarthritis, included plans of care for the certification periods 11/27/15 - 1/25/15 and 1/26/15 - 3/26/15. The plan of care for certification period of 11/27/14 - 1/25/15 had home health aide visits ordered for week 1 : 4-8 hours per day, 2 - 4 days per week and week 2 - 8 4-8 hours per day, 4 - 7 days per week to assist with shower, shampoo, bathing, dressing / undressing and nail / skin / oral / hair care. The plan of care for the certification period of 1/26/15 - 3/26/15 had home health aide visits ordered for weeks 1 - 9 : 4 - 8 per day, 4 - 7 days per week to assist with shower, shampoo, bathing, dressing / undressing and nail / skin / oral / hair care. The agency failed to complete supervisory registered nurse visits every 30 days. A. The RN completed supervisory visits on 11/25/14 and 1/21/15. B. The HHA completed HHA visits on 11/26/14, 11/27/14, 11/28/14, 12/1/14, 12/2/14, 12/3/14, 12/4/14, 12/5/14, 12/8/14, 12/9/14, 12/10/14, 12/11//14, 12/12/14, 12/15/14, 12/16/14, 12/17/14, 12/18/14, 12/19/14, 12/22/14, 12/23/14, 12/24/14, 12/26/14, 12/29/14, 12/30/14, 12/31/14, 1/1/15, 1/2/15, 1/5/15, 1/7/15, 1/8/15, 1/9/15, 1/12/15, 1/13/15, 1/14/15,			

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	1/15/15, 1/16/15, 1/19/15, 1/20/15, 1/21/15, 1/22/15, 1/23/15, 1/26/15, 1/27/15, 1/28/15, 1/29/15, 1/30/15, 2/2/15, 2/4/15, 2/6/15, 2/9/15, 2/10/15, 2/11/15, 2/12/15, 2/13/15, 2/16/15, 2/17/15, 2/18/15, 2/19/15, 2/20/15, 2/23/15, 2/24/15, 2/25/15, 2/26/15, 2/27/15, 3/2/15, and 3/25/15. C. On 3/26/15 at 4 PM, Employee A, the administrator, indicated the supervisory visits had not been completed every 30 days. 3. Clinical record 6, SOC 8/14/14 and diagnosis of seizure disorder, included plans of care for the certification periods of 12/12/14 - 2/9/15 and 2/10/15 - 4/10/15. The plan of care for the certification period of 12/12/14 - 2/9/15 included orders for the HHA to visit 1 - 2 hours a day, 1 - 2 times a day, 2 - 3 days for the first week and 1 - 2 hours a day, 5 - 7 days a week for weeks 2 - 8, and 1 - 2 hours / day, 1 - 2 times a day, 0 -1 days a week for week 9. The HHA was to assist with shower, shampoo, bathing, dressing / undressing, nail / skin, oral / hair / nail care. The plan of care for the certification period of 2/10/15 - 4/10/15 included orders for the HHA to visit 2 - 4 days / day, 5 - 7 days a week for 9 weeks. HHA was to assist with shower, shampoo, bathing, dressing / undressing,			

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	nail / skin, oral, hair care. A. The RN completed supervisory visits on 12/9/14 and 2/9/15. B. Home health aide visits occurred on 12/12/14, 12/13/14, 12/14/14, 12/16/14, 12/17/14, 12/18/14, 12/19/14, 12/20/14, 12/22/14, 12/23/14, 12/24/14, 12/28/14, 12/29/14, 12/30/14, 12/31/14, 1/2/15, 1/3/15, 1/5/15, 1/6/15, 1/7/15, 1/8/15, 1/9/15, 1/10/15, 1/11/15, 1/12/15, 1/13/15, 1/14/15, 1/15/15, 1/17/15, 1/18/15, 1/19/15, 1/20/15, 1/21/15, 1/22/15, 1/23/15, 1/24/15, 1/27/15, 1/25/15, 1/26/15, 1/28/15, 1/29/15, 1/30/15, 1/31/15, 2/2/15, 2/3/15, 2/4/15, 2/5/15, 2/10/15, 2/11/15, 2/12/15, 2/13/15, 2/14/15, 2/15/15, 2/16/15, 2/17/15, 2/18/15, 2/21/15, and 2/22/15. C. On 3/26/15 at 4:02 PM, Employee A, the administrator, indicated the supervisory visits had not been completed every 30 days. 4. Clinical record #10, SOC 8/5/14 and diagnosis of dementia, included plan of cares for the certification periods of 12/3/14 - 1/30/15 and 1/31/15 - 3/31/15. The plan of care for the certification period of 12/3/14 - 1/30 /15 included orders for the HHA to visit 2 - 4 hours a day, 1 - 2 days a week, 3 - 5 days for the			

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	first week, and 2 - 4 hours / day, 3 - 5 days per week for 8 weeks. HHA was to assist with shower, shampoo, bathing, dressing / undressing, nail / skin, oral, hair care as tasks for both of these plans of care. A. The RN completed supervisory visits on 12/2/14 and 1/28/15. B. Home health aide visits occurred on 12/1/14, 12/3/14, 12/5/14, 12/8/14, 12/10/14, 12/12/14, 12/15/14, 12/17/14, 12/19/14, 12/20/14, 12/21/14, 12/22/14, 12/24/14, 12/26/14, 12/30/14, 12/31/14, 1/2/15, 1/5/15, 1/7/15, 1/14/15, 1/16/15, 1/19/15, 1/21/15, 1/28/15, 1/30/15, 2/2/15, 2/13/15, 2/16/15, 2/18/15, 2/25/15, 2/27/15. C. On 3/24/15 at 3:10 PM, Employee A, the administrator, indicated the supervisory visits had not been completed every 30 days. 5. The agency policy titled "Home Health Aide Supervision" with an addendum date of 3/23/15 stated, "Agency shall provide Home health aide services under the direction and supervision of a Registered Nurse ... when personal care services are indicated and ordered by a physician. The frequency and supervision in response to Medicare			

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	regulations, agency policy and other state or federal requirements ... the state regulations indicate that a patient who does not require the skilled services of a nurse, a registered nurse must make a supervisory visit to the patient's residence at least once every 30 days."			